
State: Arkansas **Filing Company:** Kansas City Life Insurance Company
TOI/Sub-TOI: L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: GA175 - GA176
Project Name/Number: GA175 - GA176/GA175 - GA176

Filing at a Glance

Company: Kansas City Life Insurance Company
Product Name: GA175 - GA176
State: Arkansas
TOI: L04G Group Life - Term
Sub-TOI: L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium
Filing Type: Form
Date Submitted: 10/30/2012
SERFF Tr Num: KCLF-128729592
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: GA175 - GA176

Implementation: On Approval
Date Requested:
Author(s): Bobby Stow
Reviewer(s): Linda Bird (primary)
Disposition Date: 11/02/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State:	Arkansas	Filing Company:	Kansas City Life Insurance Company
TOI/Sub-TOI:	L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium		
Product Name:	GA175 - GA176		
Project Name/Number:	GA175 - GA176/GA175 - GA176		

General Information

Project Name: GA175 - GA176	Status of Filing in Domicile: Pending
Project Number: GA175 - GA176	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 11/02/2012	
State Status Changed: 11/02/2012	Deemer Date:
Created By: Bobby Stow	Submitted By: Bobby Stow
Corresponding Filing Tracking Number:	

Filing Description:

With this filing, Kansas City Life Insurance Company is submitting for review and approval GA175-AR, Group Insurance Enrollment Form, and GA176-AR, Group Health Statement. The Medical Information Bureau, MIB, has mandated a change to the authorization found on the second page of each form. The required change has been made to previously approved GA173-AR, Group Insurance Enrollment Form, and GA128A, Group Health Statement, to comply with the MIB mandated change. GA173-AR was approved by the Arkansas Department of Insurance on December 11, 2008.

The authorizations contained on page 2 have been amended to include the MIB required change. The following sentence has been added to the authorization on page 2 of GA175-AR and GA176-AR: "I authorize Kansas City Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB." No part of the applications have been altered or changed, and remain identical to the previously approved forms.

Company and Contact

Filing Contact Information

Bobby Stow, Compliance Analyst I	bstow@kclife.com
3520 Broadway St.	816-753-7299 [Phone] 8852 [Ext]
Kansas City, MO 64111	816-753-3018 [FAX]

Filing Company Information

Kansas City Life Insurance Company	CoCode: 65129	State of Domicile: Missouri
P O Box 219139	Group Code: 588	Company Type: Life
Kansas City, MO 64121-9139	Group Name:	State ID Number:
(800) 821-5529 ext. [Phone]	FEIN Number: 44-0308260	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	Yes
Fee Explanation:	Missouri retaliatory fee - \$50.00.
Per Company:	No

SERFF Tracking #: KCLF-128729592

State Tracking #:

Company Tracking #: GA175 - GA176

State: Arkansas

Filing Company: Kansas City Life Insurance Company

TOI/Sub-TOI: L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name: GA175 - GA176

Project Name/Number: GA175 - GA176/GA175 - GA176

Company	Amount	Date Processed	Transaction #
Kansas City Life Insurance Company	\$50.00	10/30/2012	64393105
Kansas City Life Insurance Company	\$50.00	10/31/2012	64424539

State:	Arkansas	Filing Company:	Kansas City Life Insurance Company
TOI/Sub-TOI:	L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium		
Product Name:	GA175 - GA176		
Project Name/Number:	GA175 - GA176/GA175 - GA176		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/02/2012	11/02/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Linda Bird	10/30/2012	10/30/2012

Response Letters

Responded By	Created On	Date Submitted
Bobby Stow	10/31/2012	10/31/2012

State:	Arkansas	Filing Company:	Kansas City Life Insurance Company
TOI/Sub-TOI:	L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium		
Product Name:	GA175 - GA176		
Project Name/Number:	GA175 - GA176/GA175 - GA176		

Disposition

Disposition Date: 11/02/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Cover Letter		Yes
Supporting Document	Statement of Variability - GA175-AR		Yes
Form	Group Insurance Enrollment Form		Yes
Form	Health Statement		Yes

State: Arkansas **Filing Company:** Kansas City Life Insurance Company
TOI/Sub-TOI: L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: GA175 - GA176
Project Name/Number: GA175 - GA176/GA175 - GA176

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/30/2012
Submitted Date	10/30/2012
Respond By Date	11/30/2012

Dear Bobby Stow,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

Comments:

Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$50.00 filing fee is received.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

State: Arkansas **Filing Company:** Kansas City Life Insurance Company
TOI/Sub-TOI: L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: GA175 - GA176
Project Name/Number: GA175 - GA176/GA175 - GA176

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/31/2012
Submitted Date	10/31/2012

Dear Linda Bird,

Introduction:

Thank you for your correspondence regarding the above referenced filing.

Response 1

Comments:

The additional \$50.00 filing fee has been submitted through SERFF.

Related Objection 1

Comments:

Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$50.00 filing fee is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Your continued review and consideration for this filing is appreciated.

Sincerely,

Bobby Stow

State:	Arkansas	Filing Company:	Kansas City Life Insurance Company
TOI/Sub-TOI:	L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium		
Product Name:	GA175 - GA176		
Project Name/Number:	GA175 - GA176/GA175 - GA176		

Form Schedule

Lead Form Number: GA175								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Group Insurance Enrollment Form	GA175-AR	AEF	Initial		42.700	GA175-AR.pdf
2		Health Statement	GA176-AR	AEF	Initial			GA176-AR.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



GRP # _____

Kansas City Life Insurance Company

Group Insurance Enrollment Form

COMPLETED BY EMPLOYER

1. Employer		2. Location	
3. Full-time employment date	4. Occupation	5. Hours worked/week	6. Annual earnings
7. Coverage class	8. Rehire date	9. This enrollment is: (check all that apply) <input type="checkbox"/> Initial enrollment <input type="checkbox"/> Late entrant <input type="checkbox"/> New hire <input type="checkbox"/> Change <input type="checkbox"/> Other _____	

COMPLETED BY EMPLOYEE

10. Last Name, First Name, Middle Initial			
11. Home Address, City, State and Zip			
12. Social Security Number	13. <input type="checkbox"/> Male <input type="checkbox"/> Female	14. Date of Birth (M/D/Y)	15. <input type="checkbox"/> Single <input type="checkbox"/> Married

To apply for coverage(s), complete the following section and sign below. Indicate only those products available through your employer/plan sponsor.

16. Coverage(s) for Employee: <input type="checkbox"/> Basic Life & AD&D <input type="checkbox"/> Voluntary/Supplemental Life Amount: _____ <input type="checkbox"/> Dental If Applicable: <input type="checkbox"/> Low Plan <input type="checkbox"/> High Plan <input type="checkbox"/> Short-Term Disability <input type="checkbox"/> Voluntary STD If Applicable: Amount: _____ <input type="checkbox"/> Long-Term Disability <input type="checkbox"/> Voluntary LTD If Applicable: Amount: _____ <input type="checkbox"/> Vision	17. Coverage(s) for Dependents (Employee coverage required) <input type="checkbox"/> Dependent Life <input type="checkbox"/> Spouse Voluntary/Supplemental Life Amount: _____ <input type="checkbox"/> Child/ren Voluntary/Supplemental Life Amount: _____ Dental: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren Vision: <input type="checkbox"/> Spouse <input type="checkbox"/> Child/ren
---	---

[18. If COBRA continuee, please supply qualifying event and date:]

[19. Full Name of Primary Beneficiary and Relationship to you (applicable to life insurance only):]

[20. Full Name of Contingent Beneficiary and Relationship to you (applicable to life insurance only):]

For Dependent Coverage: List each dependent you wish to insure.

21. Name (show last name if different from employee)	Gender	Relationship	Date of Birth	[Other Dental Coverage]	
Spouse		N/A		Y	N
Child				Y	N
Child				Y	N
Child				Y	N
Child				Y	N

By signing below, I acknowledge I have read and I agree to the terms of the Provisions of Coverage contained on the reverse side of this Enrollment Form.

22. Signature of Employee: _____ Date: _____

(To decline any coverages, complete "Declination of Coverage" on page 2.)

PLEASE DO NOT FILL IN SHADED AREA BELOW - HOME OFFICE USE ONLY

Group No. _____	Effective Date (M/D/Y)	Class	Coverage Amount
Loc/Div _____			
Cert. # _____			
_____ Approved as requested	Basic Life& AD&D		
_____ Approved with changes	Basic Dep. Life		
	Vol/Supp Life EE		
	Vol/Supp Life SP		
Employee _____	Vol/Supp Life Child		
Spouse _____	STD		
Child/ren _____	LTD		
By: _____	Dental		
Date: _____	Vision		

***PROVISIONS OF COVERAGE**

- I hereby apply to Kansas City Life Insurance Company for Group Insurance as presented to me and authorize my employer to make any necessary deduction from my wages to pay the premium when my insurance becomes effective.
- I represent I am not presently disabled and I am performing the material and substantial duties of my occupation for at least the number of hours as shown in column 5.
- Any person who knowingly presents a false for fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of crime and may be subject to fines and confinement in prison.
- I understand any material misstatement on this enrollment form may result in a denial of a claim and/or discontinuance of coverage.
- I have made a copy of this application for my records.

DECLINATION OF COVERAGE

To refuse coverage(s) for which you are required to pay a portion of the premium, please complete the following section:

Last Name, First Name, Middle Initial

Employer

Indicate Coverage(s) Declined Below:

Coverage(s) for Employee:

☐ Basic Life & AD&D]

☐ Voluntary/Supplemental Life]

☐ Dental]

☐ Voluntary STD]

☐ Short-Term Disability]

☐ Voluntary LTD]

☐ Long-Term Disability]

☐ Vision]

Coverage(s) for Dependents (Employee coverage required):

[Life: ☐ Spouse ☐ Child/ren]

[Dental: ☐ Spouse ☐ Child/ren]

[Vision: ☐ Spouse ☐ Child/ren]

Reason for refusing coverage: _____

I have been given an opportunity to participate in the group insurance plan offered by my employer. I am refusing the coverage indicated. I fully understand by this refusal, I and/or my dependents will not be entitled to any benefits under these coverages marked. If I and/or my Spouse or Child(ren) desire to participate at a later date, coverage(s) may be limited and proof of insurability may be required at my own expense.

Signature: _____

Date: _____

If requested to do so by Kansas City Life Insurance Company, please complete the following items.

Name of Employee:

Age

Gender

Height

Weight

Weight change in last year (gain/loss)

Name of Spouse of Employee (if applicable):

Age

Gender

Height

Weight

Weight change in last year (gain/loss)

During the past five years, have you (or anyone proposed for coverage) been diagnosed or treated by a member of the medical profession for any of the following: heart condition (including high blood pressure)*; cancer or tumor; chronic/recurrent respiratory disease; diabetes; kidney or liver disease; arthritis or any other disease of the joints, including neck and back disorders; any mental, emotional or nervous disorder; any disorder of the brain, nervous, digestive or reproductive system; muscle or connective tissue disorder; alcohol or drug abuse; or Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?

Employee: ☐ Yes ☐ No

Spouse (life coverage only): ☐ Yes ☐ No

During the past five years, have you been declined coverage for any life or disability insurance?

Employee: ☐ Yes ☐ No

Spouse (life coverage only): ☐ Yes ☐ No

For female, disability applicants only: Are you currently pregnant? ☐ Yes ☐ No

Please supply full details to "Yes" answers. List date(s) of onset, last occurrence, types of treatment including medication. *For high blood pressure, give date and last reading. If you require additional space, please attach separate sheet.

I(we) authorize the following to give information (defined below) to Kansas City Life Insurance Company or any person or group acting on the part of Kansas City Life Insurance Company: any medical professional, medical care institution, the Medical Information Bureau, Inc., insurer, reinsurer, government agency, consumer reporting agency or employer. I authorize Kansas City Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. "Information" means facts of: a medical nature regarding my physical or mental condition; employment; other insurance coverage; or any other non-medical facts. I(we) understand that this information will be used by Kansas City Life Insurance Company to determine eligibility for insurance. I(we) agree this Authorization is valid for two and one-half years from the date signed. I (we) know that I(we) have a right to receive a copy of this Authorization upon request. I(we) agree that a photographic copy of this Authorization is as valid as the original.

I hereby represent that the above answers are complete and true to the best of my knowledge and belief concerning the past and present state of health and medical history of the person(s) to whom the answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits.

Signature of Employee: _____

Date: _____

Signature of Spouse: _____

Date: _____



KANSAS CITY LIFE
INSURANCE COMPANY

Group Number _____

Health Statement

Policyholder _____

Print full names of all to be insured.	Relationship to Primary Insured	Birthdate			Age	Sex	Build			*Weight Change in past year	
		Month	Day	Year			Ft.	In.	Lb.	Gain	Loss
1.											
2.											
3.											
4.											
5.											
6.											

Questions apply to all Proposed Insureds*

*Give DETAILS to Yes answers. Identify Proposed Insured(s), question, specify conditions, severity, dates, duration, after-effects, weight gain or loss, and names and addresses of all attending physicians and medical facilities.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Do you take prescription medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you currently pregnant? Due Date? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever used or received treatment or counseling for the use of marijuana, heroin, cocaine, amphetamines, barbiturates, hallucinogenic agents or opium or its derivatives? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have any of the Proposed Insureds used any form of nicotine/tobacco in the last 12 months? (i.e., cigar, pipe, smokeless tobacco, cigarettes, etc.) If cigarettes, how many packs per day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you sought advice, been treated or arrested for the use of alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |

During the **last 5 years** have you:

- | | | |
|--|--------------------------|--------------------------|
| 6. been hospitalized or had medical advice, diagnostic tests recommended, or treatment by a physician or other medical practitioner? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

During the **last 10 years** have you been diagnosed or treated for any disease or disorder of:

- | | | |
|---|--------------------------|--------------------------|
| 7. brain and nervous system - mental illness, epilepsy, seizures, stroke, paralysis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. sight or hearing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. blood - anemia or leukemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. tumor or cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. heart/blood vessels - murmur, chest pain or pressure, palpitations, heart attack? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. thyroid or glandular trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. lungs - asthma, emphysema, tuberculosis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. digestive system - ulcer, intestines or rectum, polyps, colitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. liver - elevated enzymes, cirrhosis, hepatitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. diabetes - sugar in urine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. kidney/bladder or prostate - albumin, blood or pus in urine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. bone, joint, muscles, back or spine - arthritis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. breasts, uterus, ovaries? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. menstruation or pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |

Have you ever been diagnosed or treated for:

- | | | |
|---|--------------------------|--------------------------|
| 22. a sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Acquired Immune Deficiency Syndrome (AIDS) or tested HIV positive? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. In the past 3 years , have you applied for life or health insurance or reinstatement thereof, without receiving it exactly as requested? | <input type="checkbox"/> | <input type="checkbox"/> |

Names, addresses and phone numbers of personal or family physicians. (If none, list last physician, clinic or hospital consulted.)

Date and Reason: _____ Clinic or VA last consulted: _____

Claim Number: _____

Agreement and Signatures

It is understood and agreed as follows:

1. The statements and answers recorded in all parts of this application are true and complete.
2. No information regarding any Proposed Insured(s) will be considered known by the Company unless explicitly set out in writing on this application.
3. This application, and the answers to any required medical exam, will become a part of any insurance issued on it.
4. No agent has the authority to waive any of the Company's rights or rules, or to make or change any contract.
5. I (We) have received the Notice of Information Practices which explains my (our) rights under the Fair Credit Reporting Act.

AUTHORIZATION: I (We) authorize the following to give information (defined below) to Kansas City Life or any person or group acting on the part of Kansas City Life: any medical professional, medical care institution, the Medical Information Bureau, Inc., insurer, reinsurer, government agency, consumer reporting agency or employer. I authorize Kansas City Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. "Information" means facts of: a medical nature in regard to my (our) physical or mental condition; employment; other insurance coverage; or any other non-medical facts.

I (We) understand that this information will be used by Kansas City Life to determine eligibility for insurance. I (We) agree this Authorization is valid for two and one-half years from the date signed.

I (We) know that I (we) have a right to receive a copy of this Authorization upon request.

I (We) agree that a photographic copy of this Authorization is as valid as the original.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated at _____ this _____ day of _____, _____
(City, State) (Day) (Month) (Year)

Employee's Signature

Spouse's Signature (if coverage applied for)

EMPLOYER SECTION:

Reason for Submitting Health Statement:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Late Applicant | <input type="checkbox"/> Adding Coverage | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Late Dependent | <input type="checkbox"/> Increasing Coverage | _____ |

Coverage Type and Amount Applying For:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Life \$ _____ | <input type="checkbox"/> WDI \$ _____ |
| <input type="checkbox"/> Supplemental Life \$ _____ | <input type="checkbox"/> LTD \$ _____ |
| <input type="checkbox"/> Dependent Life: Spouse _____ | Child _____ |

Information Provided By

Phone #

Date

HOME OFFICE USE ONLY:

Basic Max. _____	EOI _____
Supp. Max. _____	EOI _____
Combined Max. _____	EOI _____
WDI Max. _____	
LTD Max. _____	
Notes: _____	

Amount to be Approved	Basic _____
	Supp. _____
	Total _____

Underwriting Action:

Approved ☐
Declined ☐
Withdrawn ☐

UND. _____

Decision Date _____

Notes: _____



KANSAS CITY LIFE
INSURANCE COMPANY

To obtain further information contact:
New Business Department
Kansas City Life Insurance Company
PO Box 219371
Kansas City, MO 64121-9371

NOTICE OF INFORMATION PRACTICES

Including Fair Credit Reporting Act Notice and MIB, Inc. Notice

Thank you for your application. It is the major source of information about you which we use in evaluating your application and issuing your contract. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living (except as may be related directly or indirectly to your sexual orientation) as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Home Office at the address above. You may receive a copy of such report by contacting the reporting agency. Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency.

We are committed to protecting the privacy of our customer's nonpublic personal information. We will only disclose our customer's nonpublic personal information: among the affiliated companies of the Kansas City Life Group; to provide services to our customers and administer our business; to market products; and as otherwise permitted by law. We may disclose our customer's nonpublic personal information to our agents and representatives to provide services to our customers and for marketing purposes. When we contract with other entities to provide support or marketing services, we will require them to adhere to our privacy standards.

Sometimes we acquire medical information about our customers, for instance, to underwrite an insurance contract or to process an insurance claim. We will keep our customer's medical information confidential. We will not share our customer's medical information even among the affiliated companies of the Kansas City Life Group without the customer's consent. We will only use or disclose our customer's medical information to underwrite insurance, process claims, administer our business, to comply with laws and regulations or as otherwise authorized by our customers.

You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate.

If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our New Business Department, Kansas City Life Insurance Company, PO Box 219371, Kansas City, MO 64121-9371.

MIB, Inc. Notice

While the information you provide to us regarding you insurability is treated as confidential, Kansas City Life or its reinsurers may make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. Should you apply for life or health insurance, or submit a claim for benefits to another member company, the Medical Information Bureau, upon request from that member company, will supply the information in its file.

Upon written request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is PO Box 105, Essex Station, Boston, MA 02112. Telephone (617) 426-3660.

We or our reinsurers may also release information in our file to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

State:	Arkansas	Filing Company:	Kansas City Life Insurance Company
TOI/Sub-TOI:	L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium		
Product Name:	GA175 - GA176		
Project Name/Number:	GA175 - GA176/GA175 - GA176		

Supporting Document Schedules

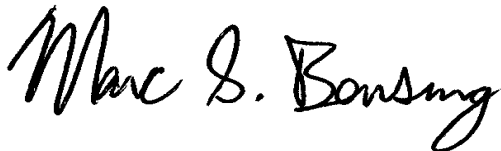
		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Readability Certification - Arkansas.pdf			
Filing Certification - Arkansas.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter		
Comments:	Attached is a letter describing the filing.		
Attachment(s):			
Cover Letter - Arkansas.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability - GA175-AR		
Comments:	Attached is a Statement of Variability for GA175-AR.		
Attachment(s):			
Statement of Variability for GA175.pdf			

READABILITY CERTIFICATION

Form	Score
GA175-AR	42.7



Name: Marc Bensing
Title: Assistant Vice President
Company: Kansas City Life Insurance Company
Date: October 16, 2012

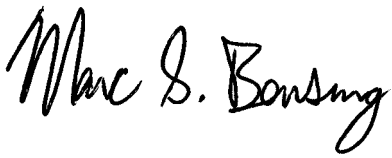
STATE OF ARKANSAS COMPLIANCE CERTIFICATION

COMPANY NAME: Kansas City Life Insurance Company

FORM TITLE(S): Group Insurance Enrollment Form, Health Statement

FORM NUMBER(S): GA175-AR, GA176-AR

I hereby certify that to the best of my knowledge and belief, the above form and submissions is in compliance with Regulation 19, Regulation 49, and all other laws, rules and regulations of the State of Arkansas.

A handwritten signature in black ink, reading "Marc S. Bensing". The signature is written in a cursive style with a horizontal line underneath.

Marc S. Bensing
Assistant Vice President
Kansas City Life Insurance Company

October 16, 2012



**KANSAS CITY LIFE
INSURANCE COMPANY**

Broadway at Armour / Box 219139 / Kansas City, Missouri 64121-9139
Telephone: (816) 753-7000

October 23, 2012

Arkansas Department of Insurance
1200 W. Third Street
Little Rock, Arkansas 72201-1904

RE: Kansas City Life Insurance Company

NAIC: 65129-588

FEIN: 44-0308260

Application Filing: MIB mandated change to Group Insurance Enrollment Form and Group Health Statement

Dear Sir or Madam:

With this filing, Kansas City Life Insurance Company is submitting for review and approval GA175-AR, Group Insurance Enrollment Form, and GA176-AR, Group Health Statement. The Medical Information Bureau, MIB, has mandated a change to the authorization found on the second page of each form. The required change has been made to previously approved GA173-AR, Group Insurance Enrollment Form, and GA128A, Group Health Statement, to comply with the MIB mandated change. GA173-AR was approved by the Arkansas Department of Insurance on December 11, 2008.

The authorizations contained on page 2 have been amended to include the MIB required change. The following sentence has been added to the authorization on page 2 of GA175-AR and GA176-AR: "I authorize Kansas City Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB." No part of the applications have been altered or changed, and remain identical to the previously approved forms.

Please direct all inquiries regarding this filing to me at the address, phone number, or email address contained in the file.

Sincerely,

Bobby Stow
Compliance Analyst
Kansas City Life Insurance Company
Phone: 800.821.6164
Ex: 8852
Email: bstow@kclife.com

Variable Listing for GA175 - Group Insurance Enrollment Form

Box 16. Coverages for Employee

(Any of these coverages may be removed if policyholder did not purchase.)

Box 17. Coverages for Dependents

(Any of these coverages may be removed if policyholder did not purchase.)

Box 18, 19, 20 - Cobra and Beneficiary info

(Any of these fields may be removed if policyholder did not purchase dental or life coverage.)

Box 21. Other Dental Coverage

(May be removed if Dental not purchased.)

Declination of Coverage

(Any of these coverages may be removed if policyholder did not purchase.)